Complete Summary

GUIDELINE TITLE

Screening for chlamydial infection: recommendation statement.

BIBLIOGRAPHIC SOURCE(S)

U.S. Preventive Services Task Force. Screening for chlamydial infection: U.S. Preventive Services Task Force recommendation statement. Ann Intern Med 2007 Jul 17;147(2):128-34. [9 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

This release updates a previously published guideline: Berg AO. Screening for chlamydial infection. Recommendations and rationale. Am J Prev Med 2001 Apr;20(3 Suppl):90-4. [7 references]

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Chlamydia trachomatis infection

GUIDELINE CATEGORY

Prevention
Screening

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Obstetrics and Gynecology
Pediatrics
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

- To summarize the U.S. Preventive Services Task Force (USPSTF) recommendations and supporting scientific evidence on routine screening for chlamydial infection
- To update the 2001 USPSTF recommendations on routine screening for chlamydial infection

TARGET POPULATION

All sexually active individuals, including adolescents and pregnant women

INTERVENTIONS AND PRACTICES CONSIDERED

Routine screening for chlamydial infection

MAJOR OUTCOMES CONSIDERED

Key Question 1: Does screening for chlamydial infection in non-pregnant women reduce adverse health outcomes?

Key Question 2: Does screening for chlamydial infection in pregnant women reduce adverse health outcomes?

Key Question 3: Does screening for chlamydial infection in men reduce adverse health outcomes in men, reduce adverse health outcomes in women, or reduce the incidence of infection in women?

Health outcomes of interest were defined as follows: pelvic inflammatory disease, ectopic pregnancy, infertility, and chronic pelvic pain in non-pregnant women; chorioamnionitis, premature rupture of membranes, pre-term labor, pre-term delivery, spontaneous abortion, endometritis, and low birth weight in pregnant women; and epididymitis, urethritis, prostatitis, chronic prostatitis, reactive arthritis, and urethral strictures in men.

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A focused systematic review of the literature was prepared by the Agency for Healthcare Research and Quality (AHRQ) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Availability of Companion Documents" field).

AHRQ staff conducted a systematic evidence review for each of the critical key questions.

Data Sources

The search strategy included a review of English language articles identified from PubMed between July 2000 and July 2005. Additional articles were found through bibliography reviews and discussion with experts. These searches identified 452 articles.

Study Selection

For key question 1, the review was limited to randomized controlled trials of non-pregnant women at increased risk for infection. For non-pregnant women not at increased risk, the search was expanded to include both randomized controlled trials and non-randomized prospective controlled studies. For key questions 2 and 3 (related to screening in pregnant women and men), the reviews were limited to randomized controlled trials and non-randomized prospective controlled studies.

Abstracts were reviewed by two staff members. All abstracts that were clearly within the scope of this review and those with potential or ambiguous relevance were retained. Eighteen articles were identified as potentially meeting these broad inclusion and exclusion criteria. (see Figure 1 in the evidence update [see "Availability of Companion Documents" field])

Data Extraction and Quality Assessment

Two reviewers independently reviewed the full articles of all identified studies to determine whether they met pre-determined inclusion criteria. Additional reviewers were consulted for consensus-building around 2 articles that were ultimately not included in this review. The 2 principal reviewers independently abstracted data using standardized forms from included articles to determine study quality.

Only one new poor quality study met inclusion criteria. This study addressing the effectiveness of screening for chlamydial infection among non-pregnant women at increased risk found that screening was associated with a lower prevalence of chlamydial infection and fewer reported cases of pelvic inflammatory disease at 1-year follow-up.

See the focused evidence update (see "Availability of Companion Documents" field) for information about the search strategies for 6 subsidiary questions.

NUMBER OF SOURCE DOCUMENTS

Key Question 1: Only 1 study in the current systematic review met the inclusion criteria and addressed the effectiveness of screening for chlamydial infection among non-pregnant women at increased risk. The current systematic review found no new direct trials of screening for chlamydial infection among women not at increased risk.

Key Question 2: Evidence reviewed for this report found no new randomized controlled studies or non-randomized studies addressing this topic.

Key Question 3: The current systematic review identified no randomized controlled studies or non-randomized cohort studies addressing the screening of men for chlamydial infection including the ability of screening programs to reduce the incidence of infection among women.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review was prepared by the Agency for Healthcare Research and Quality (AHRQ) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Companion Documents" field).

The USPSTF considered each link in the evidence chain for a screening service to make its recommendations (for further discussion of USPSTF methods, please see http://www.ahrq.gov/clinic/ajpmsuppl/harris1.htm). These included the accuracy of screening tests, the effectiveness of treatment, estimating the potential magnitude of benefit from screening, and bounding the potential for harms of screening and treatment.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Balance Sheets
Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

When the overall quality of the evidence is judged to be good or fair, the U.S. Preventive Services Task Force (USPSTF) proceeds to consider the magnitude of net benefit to be expected from implementation of the preventive service. Determining net benefit requires assessing both the magnitude of benefits and the magnitude of harms and weighing the two.

The USPSTF classifies benefits, harms, and net benefits on a 4-point scale: "substantial," "moderate," "small," and "zero/negative."

"Outcomes tables" (similar to 'balance sheets') are the USPSTF's standard resource for estimating the magnitude of benefit. These tables, prepared by the topic teams for use at USPSTF meetings, compare the condition specific outcomes expected for a hypothetical primary care population with and without use of the preventive service. These comparisons may be extended to consider only people of specified age or risk groups or other aspects of implementation. Thus, outcomes tables allow the USPSTF to examine directly how the preventive services affects benefits for various groups.

When evidence on harms is available, the topic teams assess its quality in a manner like that for benefits and include adverse events in the outcomes tables. When few harms data are available, the USPSTF does not assume that harms are small or nonexistent. It recognizes a responsibility to consider which harms are likely and judge their potential frequency and the severity that might ensue from implementing the service. It uses whatever evidence exists to construct a general confidence interval on the 4-point scale (e.g., substantial, moderate, small, and zero/negative).

Value judgments are involved in using the information in an outcomes table to rate either benefits or harms on the USPSTF's 4-point scale. Value judgments are also needed to weigh benefits against harms to arrive a rating of net benefit.

In making its determinations of net benefit, the USPSTF strives to consider what it believes are the general values of most people. It does this with greater confidence for certain outcomes (e.g., death) about which there is little disagreement about undesirability, but it recognizes that the degree of risk people are willing to accept to avert other outcomes (e.g., cataracts) can vary considerably. When the USPSTF perceives that preferences among individuals vary greatly, and that these variations are sufficient to make trade-off of benefits and harms a 'close-call', then it will often assign a C recommendation (see the "Recommendation Rating Scheme" field). This recommendation indicates the decision is likely to be sensitive to individual patient preferences.

The USPSTF uses its assessment of the evidence and magnitude of net benefit to make recommendations. The general principles the USPSTF follows in making recommendations are outlined in Table 5 of the companion document cited below. The USPSTF liaisons on the topic team compose the first drafts of the recommendations and rationale statements, which the full panel then reviews and edits. Recommendations are based on formal voting procedures that include explicit rules for determining the views of the majority.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. *Am J Prev Med* 2001 Apr;20(3S):21-35.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

What the United States Preventive Services Task Force (USPSTF) Grades Mean and Suggestions for Practice

Grade	Grade Definitions	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer/provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer/provide this service.
C	The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is moderate or high certainty that the net benefit is small.	Offer/provide this service only if there are other considerations in support of the offering/providing the service in an individual patient.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality or conflicting, and the balance of benefits and harms cannot be determined.	Read "Clinical Considerations" section of USPSTF Recommendation Statement (see "Major Recommendations" field). If offered, patients should understand the uncertainty about the balance of benefits and harms.

USPSTF Levels of Certainty Regarding Net Benefit

Definition: The U.S. Preventive Services Task Force defines certainty as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.

Level of Certainty	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by factors such as: • The number, size, or quality of individual studies • Inconsistency of findings across individual studies • Limited generalizability of findings to routine primary care practice; or • Lack of coherence in the chain of evidence As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.
Low	The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of: • The limited number or size of studies • Important flaws in study design or methods • Inconsistency of findings across individual studies • Gaps in the chain of evidence • Findings not generalizable to routine primary care practice; or • A lack of information on important health outcomes More information may allow an estimation of effects on health outcomes.

COST ANALYSIS

The guideline developers reviewed published cost analyses.

METHOD OF GUIDELINE VALIDATION

Comparison with Guidelines from Other Groups
External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Peer Review. Before the U.S. Preventive Services Task Force makes its final determinations about recommendations on a given preventive service, the Evidence-based Practice Center and the Agency for Healthcare Research and Quality send a draft systematic evidence review to 4 to 6 external experts and to federal agencies and professional and disease-based health organizations with interests in the topic. They ask the experts to examine the review critically for accuracy and completeness and to respond to a series of specific questions about the document. After assembling these external review comments and documenting the proposed response to key comments, the topic team presents this information to the Task Force in memo form. In this way, the Task Force can consider these external comments and a final version of the systematic review before it votes on its recommendations about the service. Draft recommendation statements are then circulated for comment from reviewers representing professional societies, voluntary organizations and Federal agencies. These comments are discussed before the final recommendations are confirmed.

Comparison with Guidelines from Other Groups. Recommendations for screening from the following groups were discussed: the American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP), the American College of Obstetricians and Gynecologists (ACOG), the American College of Preventive Medicine (ACPM), the Canadian Task Force on Preventive Health Care, and the Centers for Disease Control and Prevention (CDC).

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The US Preventive Services Task Force grades its recommendations (A, B, C, D, or I) and identifies the Levels of Certainty regarding Net Benefit (High, Moderate, and Low). The definitions of these grades can be found at the end of the "Major Recommendations" field.

Summary of the Recommendations

- The US Preventive Services Task Force (USPSTF) recommends screening for chlamydial infection for all sexually active non-pregnant young women aged 24 and younger, and for older non-pregnant women who are at increased risk. **A recommendation**
- The USPSTF recommends screening for chlamydial infection for all pregnant women aged 24 and younger, and for older pregnant women who are at increased risk. **B recommendation**
- The USPSTF recommends against routinely providing screening for chlamydial infection for women aged 25 and older, whether or not they are pregnant, if they are not at increased risk. **C recommendation**
- The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for chlamydial infection for men. **I statement**.

See "Assessment of Risk" and "Suggestions for Practice Regarding an I Statement" below for discussions of assessing risk for chlamydial infection in women and suggestions for practice regarding screening for men.

Clinical Considerations

Patient Population Under Consideration

These recommendations target all sexually active individuals, including adolescents and pregnant women.

Assessment of Risk

All sexually active women 24 years and younger—including adolescents—are at increased risk for chlamydial infection. In addition to sexual activity and age, other risk factors for chlamydial infection include a history of previous chlamydial or other sexually transmitted infection, new or multiple sexual partners, inconsistent condom use, and exchanging sex for money or drugs. Risk factors for pregnant women are the same as for non-pregnant women. Prevalence of chlamydial infection varies widely among patient populations. African American and Hispanic women have a higher prevalence of infection than the general population in many communities and settings. Among men and women, increased prevalence rates are also found in incarcerated populations, military recruits, and patients at public sexually transmitted infection clinics.

Screening Tests

Nucleic acid amplification tests (NAATs) have high specificity and sensitivity when used as screening tests for chlamydial infection. NAATs can be used with urine and vaginal swabs, enabling screening when a pelvic examination is not performed.

Treatment

Appropriate treatment of chlamydia infection has been outlined by the Centers for Disease Control and Prevention (CDC) see the National Guideline Clearinghouse (NGC) summary of the CDC guideline Clinical prevention guidance. Sexually transmitted diseases treatment guidelines 2006. In its 2006 sexually transmitted disease (STD) treatment guidelines, the CDC recommends that chlamydia infection be treated with a single oral dose of one gram of Azithromycin or seven days of twice daily oral Doxycline (100 mg). Pregnant women with chlamydial infection may be treated with a single dose of one gram of Azithromycin or Amoxicillin 500 mg orally three times daily for 7 days. Since the CDC updates these recommendations regularly, clinicians are encouraged to access the CDC website to obtain the most up-to-date information. (http://www.cdc.gov/STD/treatment).

To prevent recurrent transmission, clinicians should ensure that all sexual partners of infected individuals are tested and treated if infected, or treated presumptively.

Screening Intervals

Screening for pregnant women who are at increased risk for chlamydial infection is recommended at the first prenatal visit. For pregnant women who remain at

increased risk, and for those who acquire a new risk factor such as a new sexual partner, a screening should be conducted during the third trimester. The optimal interval for screening for non-pregnant women is unknown. The CDC recommends at least annual screening for women at increased risk.

Suggestions for Practice in the Face of Insufficient Evidence Regarding Screening in Men

The USPSTF concluded that the evidence is insufficient to determine the balance of benefits and harms related to screening men for chlamydial infection. Specifically, the USPSTF did not find evidence that screening programs that target men result in a decreased incidence of infection in women. The USPSTF notes that programs that screen men as a means of reducing transmission to women are not common practice, that primary care clinicians are capable of instituting screening in men, that the costs of additional screening tests per individual are relatively low, and that the potential harms of screening are small. The USPSTF recognizes that asymptomatic, untreated infections in men provide a reservoir of infection that may make it difficult to improve health outcomes in women through screening programs that target only women. However, given the low national rates of screening in women at risk, the USPSTF believes that clinicians and health care systems should focus on improving the screening rates among women at increased risk, a group in which the benefits of screening are certain.

Other Approaches to Prevention

Primary care clinicians and the health care systems in which they work are responsible for ensuring that asymptomatic women at risk for chlamydial infection are screened. In some communities, this may involve home- or school-based screening programs.

Useful Resources

See the NGC summaries for other USPSTF recommendations on screening for sexually transmitted infections (hepatitis B and hepatits C virus infection, HIV, genital herpes simplex, gonorrhea, and syphilis).

Definitions:

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C	The USPSTF recommends against	Offer/provide this service only if there

Grade	Grade Definitions	Suggestions for Practice
	routinely providing the service. There may be considerations that support providing the service in an individual patient. There is moderate or high certainty that the net benefit is small.	are other considerations in support of the offering/providing the service in an individual patient.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality or conflicting, and the balance of benefits and harms cannot be determined.	Read "Clinical Considerations" section of USPSTF Recommendation Statement (see "Major Recommendations" field). If offered, patients should understand the uncertainty about the balance of benefits and harms.

USPSTF Levels of Certainty Regarding Net Benefit

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Level of Certainty	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by factors such as: • The number, size, or quality of individual studies • Inconsistency of findings across individual studies • Limited generalizability of findings to routine primary care practice; or • Lack of coherence in the chain of evidence As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.
Low	The available evidence is insufficient to assess effects on health

Level of Certainty	Description
	outcomes. Evidence is insufficient because of: • The limited number or size of studies • Important flaws in study design or methods • Inconsistency of findings across individual studies • Gaps in the chain of evidence • Findings not generalizable to routine primary care practice; or • A lack of information on important health outcomes More information may allow an estimation of effects on health outcomes.

CLINICAL ALGORITHM(S)

None available

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Benefits of Detection and Early Intervention

- **Non-pregnant women at increased risk**. There is good evidence that screening for Chlamydial infection in women who are at increased risk can reduce the incidence of pelvic inflammatory disease (PID). The US Preventive Services Task Force (USPSTF) concluded that the benefits of screening women at increased risk are substantial.
- **Pregnant women at increased risk**. There are no studies evaluating the effectiveness of screening for chlamydial infection in pregnant women who are at increased risk. The USPSTF, however, found the following: 1) screening identifies infection in asymptomatic pregnant women; 2) there is a relatively high prevalence of infection among pregnant women who are at increased risk; and 3) there is fair evidence of improved pregnancy and birth outcomes for women who are treated for chlamydial infection. The USPSTF concluded that the benefits of screening pregnant women who are at increased risk are substantial.
- **Women not at increased risk**. The USPSTF identified no studies documenting the benefits of screening women, including pregnant women, who are not at increased risk for chlamydial infection. While recognizing the potential benefit to women identified through screening, the USPSTF concluded the overall benefit of screening would be small, given the low prevalence of infection among women not at increased risk.

- **Men**. While concluding that the direct benefit to men of screening was likely to be small, the USPSTF noted that screening for chlamydial infection in men may be beneficial if it were to lead to a decreased incidence of chlamydial infection in women. The USPSTF did not, however, find evidence to support this outcome, and therefore concluded that the benefits of screening men are unknown. The USPSTF identified this as a critical gap in the evidence.

POTENTIAL HARMS

Harms of Detection and Early Treatment

The U.S. Preventive Services Task Force (USPSTF) concluded that the harms of screening for chlamydial infection are no greater than small, although few studies have been published on this subject. Potential harms include anxiety and relationship problems arising from false positive results and over-treatment. The USPSTF identified the lack of evidence related to potential harms of screening as a gap in the evidence.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The U.S. Preventive Services Task Force (USPSTF) makes recommendations about preventive care services for patients without recognized signs or symptoms of the target condition.
- It bases its recommendations on a systematic review of the evidence of the benefits and harms and an assessment of the net benefit of the service.
- The USPSTF recognizes that clinical or policy decisions involved more considerations than this body of evidence alone. Clinicians and policy-makers should understand the evidence but individualize decision making to the specific patient or situation.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The experiences of the U.S. Preventive Services Task Force (USPSTF), as well as that of other evidence-based guideline efforts, have highlighted the importance of identifying effective ways to implement clinical recommendations. Practice guidelines are relatively weak tools for changing clinical practice when used in isolation. To effect change, guidelines must be coupled with strategies to improve their acceptance and feasibility. Such strategies include enlisting the support of local opinion leaders, using reminder systems for clinicians and patients, adopting standing orders, and audit and feedback of information to clinicians about their compliance with recommended practice.

In the case of preventive services guidelines, implementation needs to go beyond traditional dissemination and promotion efforts to recognize the added patient and clinician barriers that affect preventive care. These include clinicians' ambivalence about whether preventive medicine is part of their job, the psychological and

practical challenges that patients face in changing behaviors, lack of access to health care or of insurance coverage for preventive services for some patients, competing pressures within the context of shorter office visits, and the lack of organized systems in most practices to ensure the delivery of recommended preventive care.

Dissemination strategies have changed dramatically in this age of electronic information. While recognizing the continuing value of journals and other print formats for dissemination, the Agency for Healthcare Research and Quality makes all U.S. Preventive Services Task Force (USPSTF) products available through its Web site. The combination of electronic access and extensive material in the public domain should make it easier for a broad audience of users to access U.S. Preventive Services Task Force materials and adapt them for their local needs. Online access to U.S. Preventive Services Task Force products also opens up new possibilities for the appearance of the annual, pocket-size *Guide to Clinical Preventive Services*. USPSTF recommendations also are available in an electronic selector tool. The ePSS can be accessed on the Internet or downloaded to to a PDA.

To be successful, approaches for implementing prevention have to be tailored to the local level and deal with the specific barriers at a given site, typically requiring the redesign of systems of care. Such a systems approach to prevention has had notable success in established staff-model health maintenance organizations, by addressing organization of care, emphasizing a philosophy of prevention, and altering the training and incentives for clinicians. Staff-model plans also benefit from integrated information systems that can track the use of needed services and generate automatic reminders aimed at patients and clinicians, some of the most consistently successful interventions. Information systems remain a major challenge for individual clinicians' offices, however, as well as for looser affiliations of practices in network-model managed care and independent practice associations, where data on patient visits, referrals, and test results are not always centralized.

IMPLEMENTATION TOOLS

Foreign Language Translations
Patient Resources
Personal Digital Assistant (PDA) Downloads
Pocket Guide/Reference Cards
Tool Kits

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

U.S. Preventive Services Task Force. Screening for chlamydial infection: U.S. Preventive Services Task Force recommendation statement. Ann Intern Med 2007 Jul 17;147(2):128-34. [9 references] PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1996 (revised 2007)

GUIDELINE DEVELOPER(S)

United States Preventive Services Task Force - Independent Expert Panel

GUIDELINE DEVELOPER COMMENT

The U.S. Preventive Services Task Force (USPSTF) is a Federally-appointed panel of independent experts. Conclusions of the USPSTF do not necessarily reflect policy of the U.S. Department of Health and Human Services (DHHS) or DHHS agencies.

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

U.S. Preventive Services Task Force (USPSTF)

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Corresponding Author: Ned Calonge, MD, MPH, Chair, U.S. Preventive Services Task Force, c/o Program Director, USPSTF, Agency for Healthcare Research and Quality

*Task Force Members**: Ned Calonge, MD, MPH, Chair, USPSTF (Chief Medical Officer and State Epidemiologist, Colorado Department of Public Health and Environment, Denver, CO); Diana B. Petitti, MD, MPH , Vice-chair, USPSTF (Senior Scientific Advisor for Health Policy and Medicine, Regional Administration, Kaiser

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**Members of the Task Force at the time this recommendation was finalized. For a list of current Task Force members, go to* www.ahrq.gov/clinic/uspstfab.htm.

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

This release updates a previously published guideline: Berg AO. Screening for chlamydial infection. Recommendations and rationale. Am J Prev Med 2001 Apr;20(3 Suppl):90-4. [7 references]

GUIDELINE AVAILABILITY

Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site. Also available from the Annals of Internal Medicine Web site.

Print copies: Available from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

Evidence Reviews:

- Meyers, D.S., Halvorson, H., Luckhaupt, S. Screening for chlamydial infection: an evidence update for the United States Preventive Services Task Force. Rockville (MD): Agency for Healthcare Research and Quality, 2007. [24 references] Electronic copies: Available from the USPSTF Web site. Also available from the Annals of Internal Medicine Web site.
- Meyers, D.S., Halvorson, H., Luckhaupt, S. Screening for chlamydial infection: a focused evidence update for the United States Preventive Services Task Force. Rockville (MD): Agency for Healthcare Research and Quality, 2007. Evidence synthesis number 48. [53 references] Electronic copies: Available from the USPSTF Web site.
- Screening for chlamydial infection. Clinical summary of recommendations by the U.S. Preventive Services Task Force (USPSTF). Ann Intern Med 2007;147(2):131. Electronic copies: Available from the USPSTF Web site.

Background Articles:

- Barton M et al. How to Read the new Recommendation Statement: Methods Update from the U.S. Preventive Services Task Force. Ann Intern Med. 2007;147:123-127.
- Guirguis-Blake J et al. Current Processes of the U.S. Preventive Preventive Services Task Force: Refining Evidence-Based Recommendation Development. Ann Intern Med. 2007;147:117-122. [2 references]
- Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.

Electronic copies: Available from the USPSTF Web site.

The following is also available:

- The guide to clinical preventive services, 2006. Recommendations of the U.S. Preventive Services Task Force. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2006. 228 p. Electronic copies available from the AHRQ Web site.
- A step-by-step guide to delivering clinical preventive services: a systems approach. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2002 May. 189 p. Electronic copies available from the AHRQ Web site. See the related QualityTool summary on the Health Care Innovations Exchange Web site.

Print copies: Available from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

The Electronic Preventive Services Selector (ePSS), available as a PDA application and a web-based tool, is a quick hands-on tool designed to help primary care clinicians identify the screening, counseling, and preventive medication services that are appropriate for their patients. It is based on current recommendations of the USPSTF and can be searched by specific patient characteristics, such as age, sex, and selected behavioral risk factors.

PATIENT RESOURCES

The following is available:

- The Pocket Guide to Good Health for Adults. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2003.

Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site. Copies also available in Spanish from the USPSTF Web site.

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

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